CHAPTER 75-02-05
PROVIDER INTEGRITY

75-02-05-01. Purpose. The purpose underlying administrative remedies and sanctions in the medical assistance (medicaid) program is to assure the proper and efficient utilization of medicaid funds by those individuals providing medical, dental, and other health services and goods to recipients of public assistance and medically indigent persons.

History: Effective July 1, 1980.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 50-24.1-01

75-02-05-02. Authority and objective. Under authority of North Dakota Century Code chapter 50-24.1, the department of human services is empowered to promulgate such rules and regulations as are necessary to qualify for federal funds under section 1901 specifically, and title XIX generally of the Social Security Act. These regulations are subject to the medical assistance state plan and to applicable federal law and regulation.

History: Effective July 1, 1980.
General Authority: NDCC 50-06-05.1, 50-24.1-04
Law Implemented: NDCC 50-24.1-04

75-02-05-03. Definitions.

1. "Administrative or fiscal agent" means an organization which processes and pays provider claims on behalf of the division of medical services.

2. "Affiliates" means persons having an overt or covert relationship each with the other such that any one of them directly or indirectly controls or has the power to control another.

3. "Closed-end medicaid provider agreement" means an agreement that is for a specified period of time not to exceed twelve months.

4. "Exclusion from participation" means permanent removal from provider participation in the North Dakota medical assistance program.

5. "Medicaid" means "medical assistance" and is a term precisely equivalent thereto.

6. "Offsetting of payments" means a reduction or other adjustment of the amounts paid to a provider on pending and future bills for purposes of offsetting overpayments previously made to the provider.

7. "Open-end medicaid provider agreement" means an agreement that has no specific termination date and continues in force as long as it is agreeable to both parties.

8. "Person" means any natural person, company, firm, association, corporation, or other legal entity.

9. "Provider" means any individual or entity furnishing medicaid services under a provider agreement with the division of medical services.

10. "Suspension from participation" means temporary suspension of provider participation in the North Dakota medical assistance program for a specified period of time.

11. "Suspension of payments" means the withholding of payments due a provider until the resolution of the matter in dispute between the provider and the division of medical services.

History: Effective July 1, 1980.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 CFR 431.1,42 CFR 431.107

75-02-05-04. Provider responsibility. In order to assure the highest quality medical care and services, medicaid payments shall be made only to providers meeting established standards. Providers who are certified for participation in medicare shall be automatically approved for participation, providing no sanction has been imposed as provided for in section 75-02-05-08. Comparable standards for providers who do not participate in medicare are established by state law and appropriate licensing and standard-setting authorities in the health and mental health fields.

1. Payment for covered services under medicaid is limited to those services certified as medically necessary in the judgment of a qualified physician or other practitioner, for the proper management, control, or treatment of an individual's medical problem and provided under the physician's or practitioner's direction and supervision.

2. Providers agree to keep and, upon request, to make available to the division of medical services and the department of health and human

services, such records as they may, from time to time, deem necessary and proper.

3. A provider must accept, as payment in full, the amounts paid in accordance with the payment structure established for medicaid. A provider performing a procedure or service may not request or receive any payment, in addition to such established amounts, from the recipient, or anyone acting on the recipient's behalf, for the same procedure or service. In cases where a recipient liability has been properly determined by a county social service board, the provider may hold the recipient responsible for a portion of the allowable fee.

4. No medicaid payment will be made for claims received by the division of medical services later than twelve months following the date the service was provided except that any periods of time exceeding thirty days, from the time a provider requests an authorization to the time the authorization is sent to the provider, shall be added to the twelve months.

5. In all joint medicare/medicaid cases, a provider of service must accept assignment of medicare payment in order to receive payment from medicaid for amounts not covered by medicare.

6. When the recipient has other medical insurance, all benefits available due to such insurance must be applied prior to the acceptance of payment by medicaid.

7. Providers may not offer or accept a fee, portion of a fee, charge, rebate, or kickback for a medicaid patient referral.

8. Claims for payment and documentation as required must be submitted on forms prescribed by the division of medical services or its designee.

9. A provider must comply with all accepted standards of professional conduct and practice in dealing with recipients and the division of medical services.

History: Effective July 1, 1980.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 CFR 431.107

75-02-05-05. Grounds for sanctioning providers. Sanctions may be imposed by the division of medical services against a provider who:

1. Presents or causes to be presented for payment any false or fraudulent claim for care or services.

2. Submits or causes to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled.

3. Submits or causes to be submitted false information for the purpose of meeting prior authorization requirements.

4. Submits a false or fraudulent application to obtain provider status.

5. Fails to disclose or make available to the division of medical services or its authorized agent records of services provided to medicaid recipients and records of payments received for those services.

6. Fails to provide and maintain services to medicaid recipients within accepted medical community standards as adjudged by a body of peers.

7. Fails to comply with the terms of the provider certification agreement which is printed on the medicaid claim form.

8. Overutilizes the medicaid program by inducing, furnishing, or otherwise causing a recipient to receive care and services not required by the recipient.

9. Rebates or accepts a fee or portion of a fee or charge for a medicaid patient referral.

10. Is convicted of a criminal offense arising out of the practice of medicine in a manner which resulted in death or injury to a patient.

11. Fails to comply and to maintain compliance with all regulations and statutes, both state and federal, which are applicable to the applicant's/licensee's profession, business, or enterprise.

12. Is suspended or involuntarily terminated from participation in medicare.

13. Is suspended or involuntarily terminated from participation in any governmentally sponsored medical program such as workmen's compensation, crippled children's services, rehabilitation services, and medicare.

14. Bills or collects from the recipient any amount in violation of section 75-02-05-04.

15. Fails to correct deficient provider operations within a reasonable time, not to exceed thirty days, after receiving written notice of these deficiencies from the division of medical services, other responsible state agencies, or their designees.

16. Is formally reprimanded or censured by an association of the provider's peers for unethical practices.

17. Fails to change or modify delivery patterns and services within a reasonable period after receipt of a request so to do by a peer review committee whose jurisdiction includes the provider.

18. Is convicted of a criminal offense arising out of the making of false or fraudulent statements or omission of fact for the purpose of securing any governmental benefit to which the provider is not entitled, or out of conspiring, soliciting, or attempting such an action.

19. Refuses to repay or make arrangements for the repayment of identified overpayments or otherwise erroneous payments. A refusal of repayment exists if no repayment or arrangement for repayment is made within thirty days of the date written notice of discrepancy was sent.

20. Is served with a search warrant by a member of any law enforcement agency for the purpose of obtaining evidence of a crime of fraud committed, by that provider, against the medical assistance program or is charged with such a crime, provided that no provider may be terminated from participation in the medical assistance program on such grounds.

History: Effective July 1, 1980; amended effective November 1, 1983.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 12.1-11-02;42 CFR 455.11, 42 CFR 455.13

75-02-05-06. Reporting of violations and investigation. Information from any source indicating that a provider has failed or is failing to fulfill the provider's responsibilities, as set forth in section 75-02-05-04; or that a provider has acted or omitted to act in a manner which forms a ground for sanction as set forth in section 75-02-05-05 shall be transmitted to the division of medical services. The division shall forthwith investigate the matter and, should the report be substantiated, take whatever action or impose whatever sanction is deemed most appropriate. The taking of any action or the imposition of any sanction shall not preclude subsequent or simultaneous civil or criminal court action.

History: Effective July 1, 1980.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 CFR 455.14, 42 CFR 455.15, 42 CFR 455.16

75-02-05-07. Resolution prior to sanction.

1. When the staff of the division of medical services determines that a provider has been rendering care or services in a form or manner inconsistent with program regulations, or has received payment for which the provider may not be properly entitled, the division of medical

services may notify the provider in writing of the discrepancy noted. The notice to the provider will set forth:

a. The nature of the discrepancy or inconsistency.

b. The dollar value, if any, of such discrepancy or inconsistency.

c. The method of computing such dollar values.

d. Further actions which the division may take.

e. Any action which may be required of the provider.

2. When the division of medical services has notified the provider in writing of a discrepancy or inconsistency, it may withhold payments on pending and future claims in an amount reasonably calculated to approximate the amounts in question pending a response from the provider. If the division of medical services and the provider are able to satisfactorily resolve the matter, sanctions shall not be imposed.

History: Effective July 1, 1980.
General Authority: NDCC 50-24.1 04
Law Implemented: 42 CFR 455.16

75-02-05-08. Imposition and extent of sanction.

1. **Imposition of sanction.**

a. The determination of appropriate sanction shall be at the discretion of the director of the division of medical services or the director's designee.

b. The following factors shall be considered in determining the sanction to be imposed:

(1) Seriousness of the offense.

(2) Extent of the violations.

(3) History of prior violations.

(4) Prior imposition of sanctions.

(5) Prior provision of provider information and training.

(6) Provider willingness to adhere to program rules.

(7) Agreement to make restitution.

(8) Actions taken or recommended by peer groups or licensing boards.

c. When a provider has been suspended or involuntarily terminated from the medicare program, the director of the division of medical services or the director's designee shall impose the same sanction as that imposed by medicare.

d. A provider convicted of a violation of North Dakota Century Code section 12.1-24-03 shall be suspended from further participation in the medicaid program for a period of at least thirty days, or shall be terminated from participation in the medicaid program.

2. **Scope of sanction.**

a. One or more of the following sanctions may be imposed on providers who become subject to sanction:

(1) Termination from participation in the medicaid program.

(2) Suspension from participation in the medicaid program.

(3) Suspension or withholding of payments to a provider.

(4) Transfer to a closed-end provider agreement not to exceed twelve months.

(5) Mandatory attendance at provider information sessions.

(6) Prior authorization of services.

(7) One hundred percent review of the provider's claims prior to payment.

(8) Referral to the state licensing board or other appropriate body for investigation.

(9) Referral to peer review.

b. A sanction may be applied to all known affiliates of a provider, provided that each affiliate so sanctioned knew or should have known, had the affiliate properly carried out the affiliate's official duties, of the violation, failure or inadequacy of performance for which the sanction is imposed.

c. No provider who is subject to suspension or termination from participation shall submit claims for payment, either personally or through claim submitted by any clinic, group, corporation, or other association to the division of medical services or its fiscal agent

for any services or supplies provided under the medicaid program except for any services or supplies provided prior to the effective date of the suspension or termination.

d. No clinic, group, corporation, or other organization which is a provider of services shall submit claims for payment to the division of medical services or its fiscal agent for any services or supplies provided by a person within such organization who has been suspended or terminated from participation in the medicaid program except for those services and supplies provided prior to the effective date of the suspension or termination.

e. Claims submitted in violation of subdivisions c and d will be returned without processing. The submission of such claims may subject the person or organization submitting to sanction.

3. **Notice of sanction.**

a. When a provider has been sanctioned, the director of the division of medical services or the director's designee shall notify the provider in writing of the sanction imposed. Such notice will also advise the provider of the right of appeal.

b. When a provider has been sanctioned, the director of the division of medical services may notify, as appropriate, the applicable professional society, board of registration or licensure, and federal, state, or county agencies of the findings made and the sanctions imposed.

c. When a provider's participation in the medicaid program has been suspended or terminated, the director of the division of medical services or the director's designee will notify the counties from whom the provider has requested claims for services, that such provider has been suspended or terminated. Each county agency so notified shall post, in a prominent place within its office, the name and location of the suspended or terminated provider. The posting shall remain in place for the entire period of a suspension, and for the first ninety days of a termination.

History: Effective July 1, 1980.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 CFR 455.16(c)

75-02-05-09. Appeal and reconsideration.

1. Within thirty days after notice of sanction, the provider may appeal the decision to impose sanctions to the department of human services unless the sanction imposed is termination or suspension and the notice states that the basis for such sanction is:

a. The provider's failure to meet standards of licensure, certification, or registration where those standards are imposed by state or federal law as a condition to participation in the medicaid program.

b. Because the provider has been similarly sanctioned by the medicare program.

2. Appeals taken shall be governed by chapter 75-01-03, and providers shall be treated as claimants thereunder.

3. Without prejudice to any right of appeal, the provider, upon receipt of notice of sanction, may in writing, request reconsideration. Such request for reconsideration must include a statement refuting the stated basis for the imposition of the sanction. The division of medical services shall, within ten days after receipt of a request for reconsideration, make written response to the request, stating that imposition of the sanction has been affirmed or reversed.

History: Effective July 1, 1980.
General Authority: NDCC 50-24.1-04
Law Implemented: NDCC 23-01-03, 23-16-01, 23-17.1-01, 23-20.1-04, 23-27-01, 25-16-02, 26.1-18-02, 43-05-09, 43-06-08, 43-12.1-03, 43-13-15, 43-15-15, 43-17-34, 43-26-13, 43-28-10, 43-32-17, 43-33-02, 43-37-03, 50-11.1-03;NDAC 75-01-03; 42 USC 1396a(a)(39); 42 CFR 431.151

75-02-05-10. Provider information sessions.

1. Except where termination has been imposed, each provider who has been sanctioned shall participate in a provider education program as a condition of continued participation, if the division of medical services in its direction so directs.

2. Provider education programs may include any of the following topics, or may include other topics that are deemed by the division of medical services to be reasonable and necessary:

a. Instruction in claim form completion.

b. Instruction on the use and format of provider manuals.

c. Instruction on the use of procedure codes.

d. Instruction on statutes, rules, and regulations governing the North Dakota medicaid program.

e. Instruction on reimbursement rates.

f. Instructions on how to inquire about coding or billing problems.

g. Any other matter as determined by the division of medical services.

History: Effective July 1, 1980.
General Authority: NDCC 50-24.1-04
Law Implemented: 42 CFR 455.16(c)